

Instructions on back

CACFP Center Number	
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1. Name of Sponsoring Organization			
Sponsor Phone #			
Center Name			
Center Phone #			
Center Address			
City		Zip	
County			

2. An individual care plan is on file for each adult participating in CACFP (attach sample):

☐ Yes ☐ No

3. **Federal Tax Status of Center** (Check one)

☐ For-Profit ☐ Nonprofit

4. **Age range of adults currently enrolled:** _____

5. **Type of Approval** (Attach copy)

☐ OMH ☐ OFA
☐ OMRDD ☐ OHSM
☐ Other _____

6. **Approval Information** (If applicable)

Expiration Date: _____

Capacity: _____

7. **Participant Data**

By visual appearance, using your best judgment, count the number of adults in each category at this center and report these numbers below.

Racial/Ethnic Category	Number of Adults	For State Use Only Census Data
Alaskan Native or American Indian		
Asian		
Black or African American		
Hispanic or Latino		
Native Hawaiian or other Pacific Islander		
White (not of Hispanic origin)		
Other		
Total		

8. Number of adults enrolled and eligible to be claimed:

Free	Reduced	Paid	Total

9. Hours open: From _____ To _____

Days open:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

Months open:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

10. **What is the plan for meal preparation?** (Check all that apply)

- ☐ A. Prepared at this center
☐ B. Prepared at Sponsor's central kitchen
☐ C. Purchased from a local school system
☐ D. Purchased from a food service company
☐ E. Purchased from a food service company as part of an umbrella contract
☐ F. Other _____

11. **Meal Service:**

Meal Served	Usual Service		Holiday/ Weekend Schedule
	Number of Adults Served	Time Meal Served	Time Meal Served
Breakfast			
AM Snack			
Lunch			
PM Snack			
Supper			
LN Snack			

12. I certify this information is correct to the best of my knowledge.

Print name of person in charge of this center on a daily basis _____

Title _____

Signature _____

Date _____

This form is to be completed for each day care center caring for adults 18 years of age and older. Each license/registration or location is considered to be a separate center.

INSTRUCTIONS FOR COMPLETING DOH-3868

The number of each instruction corresponds to the numbered questions on the form that may need clarification.

4. Enter the age range of the adults enrolled at the center.
7. Federal civil rights laws require that each center provide this information.
8. Refer to the CACFP Income Eligibility Guidelines to estimate the number of adults in each of the reimbursement categories.
- 10B. *Prepared at the Sponsor's central kitchen.* Meals for the center are prepared at the Sponsor's kitchen and delivered to this center.
- 10D. *Purchased from a food service company.* The meals served are purchased from a food service company, caterer, restaurant, hospital, etc.
- 10E. *Purchased from a food service company as part of an umbrella contract.* An example of an umbrella contract might be an adult center on a nursing home campus. The campus is under contract with a food service company and the contract includes all food service operations on that campus.
- 10F. *Other.* If your food preparation method is not described in the options listed above, explain your specific situation.
11. Identify which meals are served at the center on a daily basis and on holidays/weekends, if different. On the line next to the meals that have been checked, enter the number of adults usually served daily and the time the meal is served. Reimbursement may only be claimed for **two** meals and **one** snack or **two** snacks and **one** meal per adult per day.
12. **This application must have the original signature of the person in charge of this center on a daily basis.**

FOR STATE USE ONLY

Date eligible for CACFP: _____

Meals approved to be claimed:

Staff Initials: _____

Date: _____

Comments: _____

